

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN7303	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/27/2010
NAME OF PROVIDER OR SUPPLIER HARRIMAN CARE & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 240 HANNAH ROAD HARRIMAN, TN 37748		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments During an on-site investigation of complaints #26416, and #26725, #25727, and 24861 conducted at Harriman Care and Rehab no deficient practices were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

K55Y11

TITLE

(X6) DATE

If continuation/sheet 1 of 1

NOV 16 2010